Health Regulation Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD12-0027	A. BUILDING _____ B. WING _____	02/08/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WARD	815 FLORAL PL, NW WASHINGTON, DC 20012

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I 000	INITIAL COMMENTS A licensing survey was conducted from February 22, 2007 through February 23, 2007. A random sample of three clients was selected from a residential population of five females with various degrees of mental retardation and other disabilities. The findings of the survey were based on observations at the group home, interviews with staff and clients, and review of records, including incident reports.	I 000		
I 043	3502.2(c) MEAL SERVICE / DINING AREAS Modified diets shall be as follows: (c) Reviewed at least quarterly by a dietitian. This Statute is not met as evidenced by: Based on interview and record review, the Group Home for persons with Mental Retardation (GHMRP) failed to ensure that one of four residents with modified diets had been reviewed at least quarterly by the consulting dietitian. (Resident s#1, #2, and #3) The finding includes: 1. Resident #1's January 2007 physician's orders and annual nutritional evaluation indicated that she was prescribed a Low-fat, Low Cholesterol diet. Review of Resident #1's records failed to show evidence that a dietitian or nutritionist had reviewed her diet plan at least quarterly. 2. Resident #2's February 2007 physician's orders and annual nutritional evaluation indicated that he was prescribed an 1800-Calorie diet. Review of Resident #2's records failed to show evidence that a dietitian or nutritionist had	I 043 #1 #2	Program Coordinator will review records monthly and schedule quarterly review of nutrition/diet. See 1043 #1.	3/30/07 3/30/07

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE Program Director — (X6) DATE 4-2-07

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I 043	Continued From page 1 evidence that a dietitian or nutritionist had reviewed her diet plan at least quarterly. 3. Resident #3 ' s February 2007 physician ' s orders and annual nutritional evaluation indicated that he was prescribed an 1800-Calorie diet. Review of Resident #3 ' s records failed to show evidence that a dietitian or nutritionist had reviewed her diet plan at least quarterly.	I 043 #3	See 1043 #1.	3/30/07
I 050	3502.8 MEAL SERVICE / DINING AREAS Each GHMRP shall serve meals for all residents, including residents who are mobile, non-ambulatory, in dining areas unless otherwise temporarily required for health reasons. This Statute is not met as evidenced by: Based on observation and interview the Group Home for persons with Mental Retardation (GHMRP) failed to serve all the residents meals in the facility's dining area. The finding includes: On February 7, 2007 at 12:13 PM, Residents #1 and #3 were observed to eat their lunch at a small breakfast table in the kitchen. Staff interview on the aforementioned date revealed that the clients eat in the kitchen because they "make too much mess. " Further observations on the aforementioned date at 6:01 PM revealed Residents #1 and #3 also eating their dinner at a breakfast table in the kitchen.	I 050	Program Coordinator will provide staff inservice training on meal service on 4/13/07.	4/13/07

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I 057	Continued From page 2	I 057		
I 057	3502.15 MEAL SERVICE / DINING AREAS Menus shall be written on a weekly basis, shall provide a variety of foods at each meal, and be varied from week to week and adjusted for seasonal changes. This Statute is not met as evidenced by: Based on observation and interview, the Group Home for persons with Mental Retardation (GHMRP) failed to ensure that menus were written on a weekly basis for five of five residents . (Residents #1, #2, #3, #4 and #5) The finding includes: Observation of the direct care staff preparing the dinner meal on February 7, 2007 at 4:37 PM revealed that the meal was prepared without a menu. Interview with the staff on the aforementioned date revealed they receive menus on a monthly basis, however, at the time of the survey, the group home failed to provide documented evidence of any menus.	I 057	Program Coordinator and House Manager will monitor facility daily for posted menu.	3/30/07
I 073	3503.3(b) BEDROOMS AND BATHROOMS Each bedroom shall be equipped with at least the following items for each resident: (b) Clean comfortable pillow; This Statute is not met as evidenced by: Based on observation and staff interview the Group Home for persons with Mental Retardation (GHMRP) failed to ensure that residents are provided with comfortable pillows. During the environmental inspection on February	I 073	Administration will purchase new pillow for resident #5 by 4/2/07. Additionally House manager will monitor facility weekly for pillows.	4/2/07

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I 073	Continued From page 3 8, 2007, the GHMRP failed to ensure Resident #5 was provided with a comfortable pillow. The resident's pillow was observed to be flat.	I 073		
I 082	3503.10 BEDROOMS AND BATHROOMS Each bathroom that is used by residents shall be equipped with toilet tissue, a paper towel and cup dispenser, soap for hand washing, a mirror and adequate lighting. This Statute is not met as evidenced by: Based on observation and staff interview the Group Home for Mentally Retarded Person (GHMRP) failed to ensure that bathrooms be equipped with paper cups. The findings include: During the environmental walk-through on February 8, 2007 , the facility failed to provide paper cups for use in any of the bathrooms used by the residents.	I 082	Program Coordinator and House manager will monitor facility bi-weekly for supplies and re-stock facility as needed.	3/30/07
I 090	3504.1 HOUSEKEEPING The interior and exterior of each GHMRP shall be maintained in a safe, clean, orderly, attractive, and sanitary manner and be free of accumulations of dirt, rubbish, and objectionable odors. This Statute is not met as evidenced by: Based on observation, the Group Home for persons with Mental Retardation (GHMRP) failed to ensure the interior of the group home was maintained in a safe, clean, orderly, attractive,	I 090		

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I 090	Continued From page 4 and sanitary manner and be free of accumulations of dirt, rubbish, and objectionable odors. The findings include: Observations of the GHMRP 's environment on February 8, 2006 are as follows: Bathroom The first floor bathroom tile was chipped at the lower part of the wall. Living Room The radiator cover in the living room had peeling paint. Dining Room One of the dining room chairs was observed missing the piece of wood extending from each side to support the legs. Bedroom 1. There was a hole in the wall behind Residents #3 and #5's bedroom door. Additionally, the Residents closet door was soiled and dirty. 2. Resident #1's second dresser was off the track. Additionally, inspection of the resident's hygiene kit revealed the resident's soap did not have a protective cover.	I 090	Bathroom: Tile was replaced.	4/13/07.
			Living room: Radiator cover was ~~painted~~ replaced.	3/30/07
			Dining room: Chair replaced.	4/13/07.
			Bedroom: #1. Hole in wall was repaired.	3/30/07.
			#2. Dresser drawer was ~~repaired~~ replaced.	3/30/07.
I 103	3504.10(e) HOUSEKEEPING Each GHMRP shall provide clean linens as follows to each resident at least weekly:	I 103	Program Coordinator and House Manager will monitor facility	3/30/07

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I 103	Continued From page 5 (e) One (1) wash cloth. This Statute is not met as evidenced by: Based on observation and staff interview the Group Home for Mentally Retarded Person (GHMRP) failed to ensure clean linens for Resident #3. The finding includes: During the environmental inspection, Resident #3's wash cloth was observed to be soiled and bleached.	I 103	cont. weekly for proper linen.	3/30/07.
I 226	3510.5(c) STAFF TRAINING This Statute is not met as evidenced by: Based on observation and staff interview, Group Home for Mentally Retarded Persons (GHMRP) failed to train staff and residents in sanitation and infection control. The findings include: Review of records failed to show evidence that the facility had trained staff and residents in sanitation and infection control as evidenced below: Observation on February 7, 2007 at 4:04 PM revealed Resident #2 sitting at the dining room table with fake money. The resident was observed to sneeze and wipe her nose with her hand. A direct care staff was present at the time, however, the staff was not observed to encourage the client to wash her hands or offer	I 226	Program Coordinator will provide staff training on 4/13/07 and monthly thereafter.	4/13/07.

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I 226	Continued From page 6 the client a tissue to wipe her nose.	I 226		
I 229	3510.5(f) STAFF TRAINING Each training program shall include, but not be limited to, the following: (f) Specialty areas related to the GHMRP and the residents to be served including, but not limited to, behavior management, sexuality, nutrition, recreation, total communications, and assistive technologies; This Statute is not met as evidenced by: Based on staff interview and record review, the Group Home for persons with Mental Retardation (GHMRP) failed to ensure each employee with initial and continuing training that enables the employee to perform duties competently for one of four clients residing in the facility. (Resident #1) The finding includes: Observation on February 7, 2007 revealed Resident #3 appeared to be obese and was prescribed. The direct care staff was asked if the resident was on a special diet and after hesitating she said no, "they just can't have fried foods. Review of the resident's physician's orders dated December 2006 revealed she had been prescribed a Low Cholesterol-Low Fat -High Fiber, Soft Texture Chopped diet. Review of the GHMRP's training records revealed that the most current training in nutrition was held on February 17, 2006.	I 229	Program Coordinator will provide staff training on nutrition Plans and implementation on 4-13-07 and at least quarterly thereafter.	4-13-07

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I 260	Continued From page 7	I 260		
I 260	3512.1 RECORDKEEPING: GENERAL PROVISIONS Each Residence Director shall maintain current and accurate records and reports as required by this section. This Statute is not met as evidenced by: Based on interview and record review the Group Home for persons with Mental Retardation (GHMRP) failed to maintain current records for one of the three residents in the sample. (Resident #1) The finding includes: Interview with the Qualified Mental Retardation Professional (Qualified Mental Retardation Professional (QMRP) on February 7, 2007 revealed Client #1 had an Individual Support Plan (ISP) meeting on January 8, 2007. Review of the client ' s habilitation record on February 7, 2007 at 2:01 PM revealed an (ISP) dated January 11, 2006. There was no documented evidence of an ISP for Client #1 dated January 8, 2007.	I 260	DDS has contractors who provide ISP services. Wasa & Ward has no control over the scheduling or when the approved document is distributed.	3/30/07
I 379	3519.10 EMERGENCIES In addition to the reporting requirement in 3519.5, each GHMRP shall notify the Department of Health, Health Facilities Division of any other unusual incident or event which substantially interferes with a resident ' s health, welfare, living arrangement, well being or in any other way places the resident at risk. Such notification shall be made by telephone immediately and shall be followed up by written notification within twenty-four (24) hours or the next work day.	I 379		

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I 379	Continued From page 8 This Statute is not met as evidenced by: Based on interview record review, the GHMRP failed to ensure the Department of Health, was notified of an unusual incident or events that substantially interfered with a resident's health and welfare within twenty-four hours or the next work day. The finding includes: Observation on February 7, 2007 at 12:40 PM revealed the Qualified Mental Retardation Professional (QMRP) was overheard asking Resident #2 if she was keeping her eyes open. According to the QMRP Resident #2 fell last year. The QMRP indicated that the resident walks around with her eyes closed and that they have to remind her to keep them open. Interview with the nurse on February 8, 2007 at 11:50 AM revealed Resident #2 had a laceration to her forehead on July 25, 2006. According to the nurse the client may have fallen, getting out of the van. The nurse also indicated that the GHMRP staff had been instructed to encourage Resident #2 to keep her eyes open when walking. There was no documented evidence that this incident was reported as required.	I 379	Please find enclosed ~~copy of incident report~~ and copy of in service training on 4/2/07 on proper procedure for reporting unusual incident reports.	4-2-07
I 411	3520.12 PROFESSION SERVICES: GENERAL PROVISIONS Professional services personnel shall participate, as appropriate, on committees concerned with the GHMRP ' s programs and operations. This Statute is not met as evidenced by:	I 411		

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I 411	Continued From page 9 Based on interview and record review the Group Home for persons with Mental Retardation (GHMRP) failed to ensure the Qualified Mental Retardation Professional (QMRP) participated in the Individual Support Plan meeting for one of the three residents in the sample. (Resident #1) The finding Includes: Interview with the Qualified Mental Retardation Professional (Qualified Mental Retardation Professional (QMRP) on February 7, 2007 at 2:04 PM revealed Resident #1 had an Individual Support Plan (ISP) meeting on January 8, 2007. Further interview with the QMRP revealed that she was unable to be present for Resident #1's ISP due to a court hearing on the same day.	I 411	Program Coordinator will reschedule (request) when there is a conflict with annual Court hearing.	3/30/07
I 420	3521.1 HABILITATION AND TRAINING Each GHMRP shall provide habilitation and training to its residents to enable them to acquire and maintain those life skills needed to cope more effectively with the demands of their environments and to achieve their optimum levels of physical, mental and social functioning. This Statute is not met as evidenced by: Based on interview and record review, the Group Home for persons with Mental Retardation (GHMRP) failed to provide habilitation and training to one of the three residents's in the sample. (Resident #1) The finding includes: The GHMRP failed to provide habilitation and training for Residents #1 and #3 as evidenced below:	I 420		

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I 420	Continued From page 10 1. Interview with the Qualified Mental Retardation Professional (Qualified Mental Retardation Professional (QMRP) on February 7, 2007 at 2:04 PM revealed that Resident #1 did not have any " goals, they just ask her what she wants to do." Interview with the direct care staff on the aforementioned date at 4:13 PM revealed Resident #1 dislikes and will refuse to go to the bathroom, she is able to bathe herself, but refuses, and she also refuses to brush her teeth. Further interview with the staff revealed the client will start brushing her teeth and then she will stop, and say she needs help. " Sometimes she wants people to feed her and will sit for a very long time. We encourage her to feed herself but sometimes we have to feed her. " According to the staff " we don't work on any programs, we use to, but now, she refuses." 2. Observations on On February 7, 2007 at 11:37 AM revealed Resident #3 sitting at the kitchen table looking through a magazine. At 12:13 PM, Resident #3 was observed to eat her lunch in the kitchen with Resident #1. At 2:31 PM, Resident #3 was observed to be still sitting in the kitchen and she returned to looking through her magazine. At 2:45 PM a direct care staff was observed sitting in the kitchen with the resident describing different things as she turned the pages of the same magazine. At 2:55 PM, the staff informed the surveyor that Resident #3 was blind in one eye and she likes to look at magazines. According to the staff, the resident can see shadows, and if she were to tell her what is in the picture she might smile. At 3:30 PM, Resident #3 was observed to be still sitting in the same spot in the kitchen, looking through that the same magazine. At 4:37 PM,	I 420	#1. Program Coordinators will provide staff training on goal implementation on 4-13-07 and will monitor progress monthly. #2 Program Coordinators will provide staff training on goal implementation using BSP techniques for non-compliant behaviors on 4-13-07 and monitor progress monthly.	4-13-07 4-13-07

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I 420	Continued From page 11 Resident #3 continued sitting in the kitchen and began watching the staff prepare dinner until 5:25 PM when the meal was served. At 6:16 PM, Resident #3 was observed to go to the basement and received her medication. The resident was observed to return upstairs to the first floor and immediately proceeded to the second floor. At 6:35 PM, Resident #3 was observed in her bed. The direct care staff was observed in the basement dancing with the other residents. According to the staff she went upstairs three times to attempt to engage the resident in dancing with her housemates, but the resident refused. At the time of the survey the GHMRP failed to engage Resident #3 in any active treatment. [Also 3521.3]	I 420		
I 422	3521.3 HABILITATION AND TRAINING Each GHMRP shall provide habilitation, training and assistance to residents in accordance with the resident ' s Individual Habilitation Plan. This Statute is not met as evidenced by: Based on observation, interview, and record review, the Group Home for persons with Mental Retardation (GHMRP failed) to ensure habilitation, training and assistance was provided to its residents in accordance with their Individual Habilitation Plan(s) (IHP) for one of three residents included in the sample. (Residents #3) The findings include: 1. Review of Resident #3's habilitation record on February 8, 2007 revealed the resident had an objective to gather plastic cups and utensils to set the table. At the time of the survey, the GHMRP	I 422	#1 See 1420 #2.	4-13-07

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I 422	Continued From page 12 failed to allow the resident the opportunity to engage in this program. 2. The GHMRP failed to design an Individual Program Plan (IPP) to address recommended targeted behaviors for Resident #3 as evidenced below: a) Interview with the direct staff on February 7, 2007 revealed that the Resident #3 has a Behavior Support Plan (BSP) to address placing soiled toilet paper in her bra and socks. The BSP requires to document all occurences. The facility designed a procedure to collect behavioral data at the day program via a communication book. The staff indicated that the client sometimes comes home with toilet paper in her chest, pants and her socks. "In the beginning we started sending the book to the day program and they sent it home for approximately three days. So we have to check everyday when she comes home from the day program. Review of Resident #3's habilitation record on February 8, 2007 revealed a Behavior Support Plan (BSP) dated March 1, 2006. According to the BSP the GHMRP was instructed "to check daily with the day program through the communication book to determine if the client engaged in paper stuffing at the day program and if so, make a note of the interventions they used to prevent this behavior. At the time of the survey the GHMRP failed to ensure that the aforementioned recommendations were implemented to assist the resident in training in accordance with her BSP. b) Further review of the resident's BSP revealed she exhibits aggression,	I 422	#2 See 1420 #2.	4-13-07

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I 422	Continued From page 13 non-compliance with medical procedures and toilet/tissue stuffing. The GHMRP failed to provide evidence of objectives to reflect the aforementioned targeted behaviors.	I 422		
I 429	3521.6 HABILITATION AND TRAINING Each GHMRP Director shall arrange for each resident to be reevaluated and to receive an Individual Habilitation Plan, which is updated appropriately at least annually. This Statute is not met as evidenced by: Based on staff interview and record review, the Group Home for persons with Mental Retardation (GHMRP) failed to have a current ISP for one of the three residents in the sample. (Resident #1) The finding includes: Interview with the Qualified Mental Retardation Professional (Qualified Mental Retardation Professional (QMRP) on February 7, 2007 revealed Resident #1 had an Individual Support Plan (ISP) meeting on January 8, 2007. Review of the resident 's habilitation record on February 7, 2007 at 2:01 PM revealed an (ISP) dated January 11, 2006. At the time of the survey there was no documented evidence of an ISP for Resident #1 dated January 8, 2007.	I 429	See I260.	3/30/07
I 441	3521.7(k) HABILITATION AND TRAINING The habilitation and training of residents by the GHMRP shall include, when appropriate, but not be limited to, the following areas: (k) Mobility (including ambulation, transportation, mapping and orientation, and use of mobility	I 441		

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	HFD12-0027	A. BUILDING _____ B. WING _____	02/08/2007

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I 441	Continued From page 14 equipment); This Statute is not met as evidenced by: Based on observation, interview and record review the GHMRP failed to ensure one of three residents included in the sample wore their helmet during all waking hours as recommended. (Resident #2) On February 7, 2007 at 11:37 AM Resident #2 was observed to wear a helmet. Interview with staff revealed that the resident wears the helmet due to an unsteady gait. On February 8, 2007 at 3:37 PM, Resident #2 was observed taking her helmet off. It was almost two hours later at 5:35 PM when one of the direct care staff was overheard instructing the resident to place her helmet back on. Review of the resident's physician orders on February 8, 2007 at 11:40 AM revealed the physician ordered that the resident "must wear helmet awaken hours." At the time of the survey, the GHMRP failed to ensure that Resident #2 wore her helmet during all waking hours.	I 441	Program Coordinator will provide staff training on helmet protocol on 4-13-07. Additionally PC, House managers and nursing staff will monitor daily for proper use.	X (6) 4-13-07
I 500	3523.1 RESIDENT'S RIGHTS Each GHMRP residence director shall ensure that the rights of residents are observed and protected in accordance with D.C. Law 2-137, this chapter, and other applicable District and federal laws. This Statute is not met as evidenced by: Based on observation, interview and record review, the Group Home for persons with Mental	I 500		

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I 500	Continued From page 15 Retardation (GHMRP) failed to ensure the rights of residents were observed and protected in accordance with D.C. Law 2-137, this chapter, and other applicable District and Federal Laws. The findings include: 1. Facility staff failed to ensure resident privacy during personal care, for one of the three women in the sample. D.C. Law 2-137, Section 6-1901(2) "Secure for each resident of the District of Columbia with mental retardation...habilitation as will be suited to the needs of the person, and to assure that such habilitation is skillfully and humanely provided with full respect for the person's dignity and personal integrity..." 1. Observations on February 7, 2007 at 11:50 PM revealed Client #1 sitting in the living room in a chair. Further observation revealed the client sitting on what appeared to be a Chux. Interview with the staff on the aforementioned date verified that Client #1 was sitting on a Chux. The client remained sitting on the chux throughout the survey. According to the staff the client wears Adult Protective Undergarments (APU's) because of her incontinence. 2. Observations on February 7, 2007 at 5:05 PM revealed a direct care staff was overheard verbally prompting Resident #1 to stand-up so that she could check her to see if she was wet. The direct care staff was observed to check the resident's APU in the presence of Resident #2 and the surveyor. 3. Section 6-1961 (b) Habilitation care; habilitation program.	I 500	#1 Program Coordinator will Provide staff training on a review of residents rights to include respect personal dignity and Personal integrity on 4-13-07. #2. See 1500 #1. #3 See 1420 #1.	4-13-07 4-13-07 4-13-07

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I 500	Continued From page 16 The GHMRP failed to ensure habilitation, training and assistance was provided to its residents in accordance with their Individual Habilitation Plan(s) (IHP) for one of three residents included in the sample. [See 3521.3] 4. Section 6-1962 Living conditions; teaching of skills The GHMRP failed to provide habilitation and training to one of the three residents's in the sample. [See 3521.1] 5. Section 6-1964 Comprehensive evaluation and individual habilitation plan The GHMRP failed to ensure an annual Individual Support Plan (ISP) was provided for one of the three residents in the sample. [See 3521.6] 6. Section 6-1965 Visitors; mail; access to telephone; religious practice; personal possessions; privacy; exercise; diet; medical attention; medication. Interview with the nurse on February 8, 2007 at 11:27 AM revealed that Resident #3 was non-compliant with medical appointments. Further interview with the nurse revealed that Resident #3 refused the following medical appointments evidenced below: - Annual physical examination on December 5, 2006 because the resident refused to get off of the van. -Podiatry on January 6, 2006 refused treatment - Mammogram on July 24, 2006 resident refused to cooperate -Dental on September 15, 2006 resident refused to open her mouth	I 500 #4 #5 #6	See 1420 #1. See 1420 #1. See 1420 #2.	4-13-07 4-13-07 4-13-07

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I 500	Continued From page 17 - Nutrtionist on November 29, 2006 refused to see the Nutritionist The GHMRP failed to address the resident's non-compliance for medical appointments. 7. Section 6-1970 Mistreatment, neglect of abuse prohibited; use of restraints; seclusion; "time-out procedures. a) The GHMRP failed to ensure unusual incident reports were reported immediately to the governmental agencies as required by DC regulation (22 DCMR Chapter 35 Section 3519.10) [See 3519.10] b) On February 8, 2007 at 4:03 PM, Staff #1 was overheard asking Resident #1 "Let's go to the bathroom. The resident refused and started crying. Staff #2 was observed at 4:05 PM to pull the residents' arm until the resident came to a standing position and escorted her upstairs to the second floor. 8. Section 6-1962 Living conditions; teaching skills An interview was conducted with the GHMRP's nurse on February 8, 2007. According to the nurse, the direct care staff will wake up Resident #1 at 4:30 AM to receive her medication. The nurse further indicated that she was responsible for administering medications at several homes, and therefore she begins the facility's medication pass at 4:30 AM. Review of Resident #1's habilitation record revealed a Behavior Support Plan dated May 22, 2006. Further review of the record revealed a data sheet indicated that the resident exhibited behaviors (shouting that she did not want to get	I 500 #7 #8	See 1420 # 2. See 1420 # 2.	4-13-07 4-13-07

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I 500	Continued From page 18 up on January 2, and January 8, 2007. It should be noted both instances occured at 4:30 AM in the morning. According to the definition for D.C. Law 2-137 the "Normalization principle means the principle of aiding mentally retarded persons to obtain a lifestyle as close to normal as possible, making available to them patterns and conditions of everyday life which are as close as possible to the patterns of mainstream society." At the time of the survey the GHMRP failed to ensure Resident #1 had been provided with a lifestyle that was close to normal as possible.	I 500		